The Management of Long-Term Sickness Absence in Large Public Sector Healthcare Organisations: A Realist Evaluation Using Mixed Methods

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Journal of Occupational Rehabilitation, November 2014

The final publication is available at Springer via

http://dx.doi.org/10.1007/s10926-014-9553-2

Angela Higgins[1], Peter O'Halloran[2§], Sam Porter[2]

Occupational Health, Northern Health and Social Care Trust, Antrim Hospital, Antrim BT41 2RL, Northern Ireland, UK

[2]School of Nursing and Midwifery, Queen's University Belfast, Medical Biology Centre, 97 Lisburn Road, Belfast BT9 7BL

[§]Corresponding author

Email addresses:

AH: angela.higgins@northerntrust.hscni.net

PO: p.ohalloran@qub.ac.uk

SP: s.porter@qub.ac.uk

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Abstract

Purpose

The success of measures to reduce long-term sickness absence (LTSA) in public sector organisations is contingent on organisational context. This realist evaluation investigates how interventions interact with context to influence successful management of LTSA.

Methods

Multi-method case study in three Health and Social Care Trusts in Northern Ireland comprising realist literature review, semi-structured interviews (61 participants), Process-Mapping and feedback meetings (59 participants), observation of training, analysis of documents.

Results

Important activities included early intervention; workplace-based occupational rehabilitation; robust sickness absence policies with clear trigger points for action. Used appropriately, in a context of good interpersonal and interdepartmental communication and shared goals, these are able to increase the motivation of staff to return to work. Line managers are encouraged to take a proactive approach when senior managers provide support and accountability. Hindering factors: delayed intervention; inconsistent implementation of policy and procedure; lack of resources; organisational complexity; stakeholders misunderstanding each other's goals and motives.

Conclusions

Different mechanisms have the potential to encourage common motivations for earlier return from LTSA, such as employees feeling that they have the support of their line manager to return to work and having the confidence to do so. Line managers' proactively engage when they have confidence in the support of seniors and in their own ability to address LTSA. Fostering these motivations calls for a thoughtful, diagnostic process, taking into account the contextual factors (and whether they can be modified) and considering how a given intervention can be used to trigger the appropriate mechanisms.

Keywords: absenteeism; occupational health; organizational culture; workplace; sick leave.

Background

The rising costs of long-term sickness absence (LTSA), defined as absence of four weeks or more [1], have kept it high on the agenda of governments and industries internationally [2, 3]. For example, in 2009 in the United Kingdom (UK) LTSA accounted for 22% of total working time lost [4]. The situation is particularly acute in the public sector where the proportion of LTSA to all sickness absence is 36%, compared to 20% in the private sector [4]. The cost to Britain's largest public sector employer, the National Health Service (NHS) in England, is an estimated £1.7 billion per annum [5].

As a result of these cost pressures, many employers internationally have placed more emphasis on SA control procedures [6, 7]. However, despite increased efforts, there has been only limited improvement, particularly in the public sector, and paradoxically the costs of SA have risen significantly [4].

Various approaches and interventions have been recommended to manage and reduce LTSA. For example, undertaking ‘return-to-work’ interviews; early referral to occupational health services; flexible working; and adoption of a case management approach are all considered to be best practice [1, 8]. Consequently, a significant proportion of SA research has concentrated on the effectiveness of particular aspects of absence management, such as occupational rehabilitation, particularly following musculoskeletal injuries [9, 10].

However, the evidence for the effectiveness of these approaches is inconclusive. Recent reviews have noted the low methodological quality of much of the research [1, 11, 12]; and uncertainty is compounded by the impact of the cultural, political and organisational contexts in which SA occurs. For example, governmental and legislative approaches to SA management vary significantly across countries [7, 13]; and organisational factors such as organisation size, absence culture, organisational change and job demands also influence the success of interventions [14]. There is also an increasing recognition of the diverse factors contributing to the likelihood of an individual having LTSA, including their physical and psychological condition, the availability of primary healthcare, perceived and actual job demands, family or

caring responsibilities, economic factors such as occupational sick pay or disability benefits, and cultural elements, such as perceived tolerance of SA within the organisation [12, 14, 15].

Nevertheless, there have been few studies examining how the main processes involved in the management of LTSA are affected by the varied contexts in which they are undertaken [1, 16-18]. Consequently, there have been calls for existing research to be supplemented by detailed case studies to examine the dynamic interplay of organisational and individual factors influencing management of LTSA [17, 19].

Approach to evaluation

In view of the complex interaction of social and organisational factors in the management of LTSA, we have chosen an approach to evaluation that stems from a realist perspective [20] This posits that outcomes in open systems do not involve constant conjunction between a determinist cause and its effect. Rather they result from the complex interplay of multiple causal mechanisms, the combination and activation of which will vary in different contexts. Many factors in addition to an intervention itself - including organisational structure, cultural mores, economic capacity, and the interpretations of the individuals involved - will influence the effectiveness of an intervention. Seeing causes as tendencies allows us to find a middle way between the simplistic assumption that we can identify the factors that make an intervention effective, irrespective of its context, and the other extreme of assuming that we cannot transfer knowledge about effectiveness in one context to another [21-24].

These ideas have influenced the development of realist evaluation [22], which aims to explain the processes involved between the introduction of an intervention and the outcomes that are produced, taking into account the social relations involved in implementation. It is driven by the observation that complex interventions are often successful in some settings but not in others, so it is important to identify not just ‘what works’ but ‘what it is about a program which works for whom in what circumstances’ [22]. Realist evaluation is a theory driven approach which seeks to explain how the mechanisms embedded in an intervention alter patterns of social behaviour within a given context to produce intended or unintended outcomes [22, 25, 26]. Mechanisms can take the form of resources or sanctions, inducements or discouragements designed to change people’s behaviour in relation to a particular goal. The effect of these mechanisms will not be uniform, but will be dependent upon the context in which they are introduced. In other words, they are generative tendencies rather than constant conjunctions. Hence the classic realist evaluation formula of context + mechanism = outcome (C+M=O).

Reflecting this, we commenced our research using this formula as an analytic template. However, our data forced upon us the importance of the thoughts, feelings, perceptions and beliefs of individual stakeholders in their response to mechanisms. It seemed to us that the significance of these agential motivations as mediators between social mechanisms and behavioural outcomes [27] was not fully recognised in the equation. While realist

evaluation accepts that ‘social mechanisms are … about people’s choices and the capacities they derive from group membership’, [22] it is our concern that this distinction between individual reasoning and structural resource is in danger of being conflated in the C+M=O formula. Thus, Pawson both identifies and elides reasoning in the following definition: ‘mechanisms describe how the resources embedded in a programme influence the reasoning and ultimately the behaviour of programme subjects’ [28]. While the C+M=O formula is an adequate framework for causal explanation in the natural world, because it does not sufficiently recognise the capacity of humans to choose, it is an insufficient description of causal chains in the social world. Moreover, there are clear categorical distinctions between the components of social causality. As Bhaskar observes, there is a need to distinguish ‘between the genesis of human actions, lying in the reasons, intentions and plans of human beings, on the one hand; and the structures governing the reproduction and transformation of social activities, on the other.’ [20]’

In order to do justice to our findings, we have added another component to the formula: agency, by which we mean the cognitive, affective and conative micro-mechanisms involved in individual decision-making [27]. Thus, our stratified conception of social causality is reflected in the formula Context + Mechanism + Agency = Outcome (C+M+A=O).

With this in mind, the evaluator’s task is to identify the assumptions that provide a rationale for interventions, and to test those assumptions in practice.

The aim is to identify tendencies in outcomes that result from combinations of causal mechanisms, to illuminate the ways they are interpreted by those involved, and to make reasonable predictions as to the sorts of contexts that will help or hinder the success of interventions. Greater confidence is produced by comparing different cases (i.e. different contexts) to identify causal theories that take the form of hypothesised relationships between context, mechanism, agency, and outcome [22, 24, 29, 30].

Aim

The aim of the research was to investigate how organisational context facilitates or hinders interventions intended to manage LTSA, in order to provide evidence for enabling and sustaining effective management approaches in large public sector organisations.

Objectives

1. To identify the underlying mechanisms influencing effective and acceptable management of LTSA.

2. To investigate how these mechanisms combine with others in the organisational context to promote or inhibit sustained, effective and acceptable management of LTSA.

Methods

Ethical approval and consent

Ethical approval was granted by the Office for Research Ethics Committees Northern Ireland (application number: 09/NIR03/06). All participants gave written informed consent.

Design and setting

The research was a multi-method comparative case study of the management of LTSA within three of the five Health and Social Care (HSC) Trusts that are government funded to provide integrated health and social care services across Northern Ireland. Case studies evaluate both processes and outcomes. They not only describe what is happening but also attempt to explain why it is happening [31, 32]. Case study evaluation incorporates the unintended consequences of particular interventions, which contribute to understanding why processes are working in some circumstances but not in others [33, 34]. Comparative case studies can provide richer descriptions of the various realities across a range of different cases and contexts [35, 36].

The three Trusts included in this study (hereafter referred to as Orgs 1, 2 and 3) were chosen because they differ in their structure, size, and geographical spread; and because Org 2 serves a mainly urban population, whilst Orgs 1 and 3 serve both rural and urban communities. This facilitated comparison of approaches to LTSA management across different, though related, healthcare organisational contexts.

Org 1 employed 12,049 staff and provided a service to a population of 443,079 people, across a wide rural and urban geographical area. Org 2 provided a range of services to over 700,000 people in an urban area, and employed 20,000 staff. Org 3 employed 12,000 staff and provided a service to a population of 279,000 people, across a wide rural and urban geographical area.

Data collection was carried out in two stages between June 2009 and April 2011. At stage one, carried out in Orgs 1 and 2, we identified initial programme theories about the relationship between mechanisms and outcomes in different contexts through a realist review of the literature and by seeking descriptive empirical information about the organisations and individuals involved in the management of LTSA. At stage two, carried out in Orgs 1, 2 and 3, we engaged in a second round of data collection, with the aim of testing, refining and revising our initial theory. Org 3 was added in order to provide a further context in which to test our theories (Table 1).

Stage One: Identifying initial programme theories

1. We carried out a systematic realist review of the literature to identify the most prevalent underlying assumptions of how LTSA interventions are supposed to work, known as ‘dominant programme theories’ (DPTs), and gather systematic evidence to test and refine these theories [37]. The complexity of the data was managed by using Greenhalgh et al’s model for the diffusion of innovations in health service organisations [38] as an analytic

framework. We searched the following health databases: Medline, British Nursing Index, CINAHL, EMBASE, Health Management Information Consortium, as well as the social sciences and management databases (ABI Inform, Emerald, Sage, Swetswise and Science Direct). The search of the literature from 1950 (the NHS was created in 1948, so this seemed a reasonable limit) to 2011 identified 5576 articles, of which 269 formed the basis of the review [39]. The DPTs informed the subsequent semi-structured interviews.

2. Semi-structured interviews with policy makers (2), General Practitioners (community physicians) (3) HR executives, senior, middle, and OH managers, Trade Union representatives (20), who were key participants in the LTSA process. All interviews were audio-recorded and transcribed. Participants were purposefully sampled to ensure a wide representation of key stakeholders.

3. Documentary analysis of policies, guidelines, procedures, assessment and audit forms to illuminate the intended focus and purposes of approaches to managing LTSA.

4. Observation of formal ‘Managing Absence Training’ for Managers in each Trust, to explore the roles, responsibilities and skills associated with managing SA.

5. Two Process Mapping workshops [40] with key participants from Orgs 1 and 2 (15 and 6 participants respectively) involved in the management of SA to describe and understand the organisational response to LTSA. Process Mapping is a data gathering exercise whereby those involved in managing LTSA meet with a facilitator in order to develop a visual representation of how

the relevant procedures and processes unfold over time for the absent employee, focusing on things as they are, not as they should be.

Stage Two: Testing initial causal theories

1. Repeated interviews with key professionals selected from Stage One: policy makers (1), HR executives, senior, middle, and OH managers, Trade Union representatives (5).
2. Interviews with employees from each Trust who had returned to work following a period of LTSA (5).
3. Data collection for theory testing in Org 3 (interviews, Process-Mapping and observation of training). Interviews with HR executives, senior, middle, and OH managers, Trade Union representatives (16). Process-Mapping workshops with key participants (11)
4. Following initial analysis of data, preliminary findings were presented to senior managers, senior human resources managers and senior occupational health managers in each of the three organisations (10, 8 and 9 participants in Orgs 1, 2, and 3 respectively) and feedback obtained. This was included in the final analysis. Overall we carried out 61 interviews and obtained feedback through other means (Process Mapping and feedback meetings) from a further 59 participants. This proved sufficient to reach saturation of concepts related to LTSA.

Data analysis

NVivo 8 software was used to code data in categories identified from the realist review, focusing on, but not confined to the DPTs. The data were

analysed using an iterative coding process, taking into account additional themes that emerged during the study. At the end of Stage One of data collection, each theme was condensed from the data. The data at the end of Stage Two were also coded under existing or newly emerging themes. The final stage of analysis involved synthesis of findings from all three Trusts to compare their similarities and differences and to identify common concepts of 'what works best, for whom, in what circumstances.' The aim of the analysis was to develop 'analytic generalisation' [41] about the relationships between context, mechanism, agency and outcome.

Results

In the following paragraphs we present the main theories and contextual factors distilled from our realist review of the literature. Then, drawing on data from multiple sources and from both stages one and two of data collection, we present participants' views on our initial DPTs. Finally we synthesise this data to theorise about how organisational mechanisms interact with contextual factors to help or hinder management of LTSA.

Realist review of the literature

The realist review [39] sought to identify the DPTs about the intervention mechanisms underlying best practice, to assess the evidence for these theories, and to throw light on important enabling or disabling contextual factors.

The initial DPTs were used to help structure data collection at stage one, allowing us to test our theories at stage two. The initial DPTs are set out below in terms of the mechanisms and the contexts that tend to produce the outcome of reduced LTSA, as far as we could deduce them from the literature. The intervention is identified as (I), the mechanism (M), agency (A), the outcome (O) and the context (C).

Initial DPT One - Early Intervention

Early intervention (I) [10, 42] in the form of regular contact with absent staff initiated by employers indicates to staff that they are valued and supported by their managers and also provides the opportunity to identify any barriers to an early return to work (M). This prevents feelings of isolation from the workplace, helps to motivate staff to return to work and gives them the confidence to do so (A), leading to an earlier return to work (O). [43]. These mechanisms are less likely to occur in a context where there are long waiting times for medical treatment [10], non-compliance with organisational procedures, inadequate training of line managers and poor communication between people with responsibility for managing LTSA (C) [6, 44].

Initial DPT Two - robust sickness absence policies with clear trigger points for management action

Managers engage more effectively with LTSA and absent staff return earlier to work (O) in organisations where staff are provided with policies on LTSA (I) which clearly state the actions required by line managers and absent employees and provide rewards (e.g. attendance bonuses, flexible working)

for absent employees that engage with the process and sanctions (e.g. disciplinary procedures) for those who do not (M) [1, 1, 4, 45, 46]. It is theorised that these mechanisms will increase the authority and confidence of managers and provide incentives for staff to return to work (A). These mechanisms are more likely to lead to an earlier return in either larger unionised firms with defined organisational structures and specialist posts assigned to attendance management and employee health protection [2]; or in smaller firms, with single level organisational structures and no collective bargaining [47]. Effectiveness is further enhanced in contexts where policies have senior management support, are communicated to all sections of the company, are fully implemented, and are supported by adequate training and resourcing of line managers [47, 48]. These mechanisms are less likely to be triggered within large, geographically dispersed, multi-layered organisations and where departmental and professional boundaries can inhibit adoption of policies (C) [49].

Initial DPT Three – Workplace-based multidisciplinary occupational rehabilitation and provision of modified duties

Workplace-based occupational rehabilitation and provision of modified duties (I) ease the re-introduction of the employee to the environment and relationships of the workplace (M) [10, 49-51], thus facilitating an earlier return to work in LTSA (O). This works by motivating staff to return to work earlier and giving them the confidence to do so (A). These mechanisms are more likely to be effective in a context where programmes are carried out within or in close collaboration with the workplace. They are inhibited by low

commitment from top management; lack of opportunity for alternative duties in smaller organisations; financial constraints; resentment and resistance from co-workers and line managers; and a belief that employees must be completely fit prior to a return to work (C) [16, 49, 52].

Initial DPT Four – Personal involvement of senior managers or specialist case managers

Personal involvement of senior managers or case managers (I) facilitates improved communication and collaboration between all key stakeholders, and the development of a plan to help the employee return to work (M) [12, 43, 53]. It helps line managers to engage in effective management of LTSA (O), by increasing their sense of accountability, reducing their uncertainty, and increasing their confidence that they will receive organisational support for difficult decisions (A). This involvement is most effective in a context where senior managers have good relations with staff and trade unions but is hindered by conflicting perspectives, priorities and agendas amongst those involved (C) [42, 47, 48].

Common contextual factors identified in the review

Running through these DPTs were a common set of contextual factors, of which the most important appeared to be the level of support for LTSA interventions from senior managers; the size and structure of the organisation; the level of financial and organisational investment in managing LTSA; the differing perceptions of stakeholders [54, 55]; and the quality of relationships between managers and staff [43, 56]. These DPTs and contextual factors

were the focus of our data collection as we sought to test these programme theories in stage two.

Participants' views on our initial DPTs

Having identified initial DPTs, we then discussed them with participants, seeking their views on their credibility and on those aspects of the context that tend to promote the effectiveness and sustainability of interventions, [22]. Approaching the data in this way facilitated the next step of describing CMO configurations [22].

Early intervention

A key resource input was early intervention in the form of early contact between line manager and employee, early referral to the OH service, and early onward referral to specialist medical services and (for MSD) to physiotherapy services.

'…*I believe early intervention does have an overwhelming benefit for both the individual and the department they work in.'* (Union Rep, Org 2).

Some employees reported feeling valued, and developed greater confidence in the OH service, particularly where OH had access to resources sufficient to allow early referral and treatment.

'If I had of been waiting through the channels of my own GP, I might still have been waiting…' (Employee 3, Org 2).

However, there was evidence that managers delayed intervention, either because they simply did not believe early intervention worked; or where absence related to culturally sensitive areas such as miscarriage or mental illness: '…*maybe it is a taboo subject and they are frightened*…' (Employee 1, Org 2). Early intervention was also less likely to be well received when the employee saw it as punitive.

'Unfortunately, historically early intervention by occupational health has been seen as a stick to sort of hit staff with …it's the misconception of what it's there for.' (Union Rep, Org 2).

Robust sickness absence policies

Senior managers providing both support and accountability to line managers, and ensuring they are trained to use organisational procedures with diligence and diplomacy was thought to lead to more diligent compliance by line managers with policy and procedure for managing LTSA. This was perceived to reduce LTSA, particularly in Org 1.

'You can create the best policies but unless managers are prepared to implement them it doesn't work' (Dir. HR Org 1).

'…*the reason we've been able to get our levels down so much as a directorate is because we're really, really implementing the policy.'* (Ass.Dir 2, Org 1).

An approach that was proactive, equitable and timely was thought to produce multiple benefits. For example, uncertainty was reduced for all parties; and line managers were able to more effectively and appropriately deal with casual sickness, and if necessary terminate employment.

'… *the framework is there, is explicit for everyone to understand, those who are managing it and people who are managed within it*.' (Senior HR Executive 1, Org 1).

'…it's important to have clear parameters so that everyone knows where they stand' (OH Manager Org 1).

'… *the new policy has been effective in reducing casual absence which is good for staff who are always picking up the slack*…(Union Rep 1, Org 1).

Consistent compliance with LTSA procedures was more likely where there was effective training for managers:

'I would attribute it [lower level of sickness absence] to having one specific policy which we implemented very early on along with you know associated training…' (OH Manager, Org 1).

Training was thought to be most effective when there was an opportunity to hear real-life case studies from peers which demonstrated the benefits of implementing absence management procedures. This sort of training *'… brought issues to life in a way I could relate to and learn from.*' (Ward Manager Org 1). On the other hand, where policies were inconsistent or not understood; or senior managers operated in a culture that fears industrial tribunals, implementation was less likely.

'…some managers are still a bit reticent about taking their employees through the disciplinary process…we're not great risk-takers in the public sector…' (OH Manager, Org 2)

Workplace-based occupational rehabilitation

Another important resource input was workplace-based occupational rehabilitation (sometimes known as 'modified duties' or 'rehabilitative returns'). This is where the employee is allowed to return to work with a temporary arrangement for reduced hours or modified duties, with a view to earlier return to their original role. A radical reduction in resources for replacement cover for absent staff had made managers more open to this practice:

'…*their [managers] attitude has changed somewhat…a pair of hands is a pair of hands, to answer the telephone or to do project work.'* (OHP 1, Org 3).

This was seen as a positive initiative in that the employee could re-adjust to work, gaining confidence and re-establishing relationships; whilst the line manager and work colleagues benefited because some duties are being covered, reducing the strain for all.

'*I found I needed time even just to get used to being back at work*.' (Employee 2, Org 3).

'…*she returned to restricted nursing duties whilst awaiting surgery…it was helpful to both of us…'* (Ward Manager 1, Org 3).

The practice was more likely to succeed where managers felt empowered and motivated to offer a rehabilitative return; where they were able to communicate a desire for the employee to return, and to provide suitable productive work.

'…*if it gets someone back I don't see the problem…it's daunting coming back so if you can get someone to come back for a day and then two days, it will build them up rather than landing them back for a whole week… I don't see it as anything counterproductive actually I see it as productive*.' (Ward Manager, Org 1).

Rehabilitative returns were less likely to succeed when managers believed that the practice did not work; or that there was no scope for modifying duties;

or when managers perceived that conditions were imposed by OH and not time-limited.

'*I don't think it allows them back any earlier, I do feel that some staff will take their six months (statutory sick pay)*…' (Ward Manager 2, Org 3).

'…*sometimes these arrangements can go on for months and months and months …never-ending…'* (Senior Manager, Org 3)

Personal involvement of senior managers or specialist case managers

Participants reported that where senior managers ensured line managers were made accountable for managing LTSA, difficult decisions were more likely to be taken rather than deferred, which benefitted the organisation, and reduced uncertainty for staff. Accountability was enhanced by senior managers prioritising SA and making it part of line managers' appraisal, whilst at the same time maintaining good communication and supportive working relationships with them. Related to this was the degree to which line managers took ownership of SA. When line managers took a proactive approach, decisions were taken more quickly and procedures more fully implemented. On the other hand, when line managers lacked confidence in managing SA, they were more likely to be passive.

Contextual factors with more widespread effects: the outer context

Whilst it was possible to identify specific sets of relationships in terms of 'what works for whom and in what circumstances,' these relationships were neither

inevitable nor discrete. The various organisational characteristics and processes interacted one with another and were in turn influenced by wider social and organisational factors.

In our research the organisations were in a process of structural change and had been subjected to significant cuts in resources. The most immediate impact on the management of LTSA was the reduction in replacement cover for absent staff, which increased the workload of remaining staff and thus their own vulnerability to LTSA:

'*Yes you do rely on your workforce to do extra shifts but they get tired and then they go out sick, so it's a vicious circle* …' (Ward Manager, Org 2).

However, this was offset by factors such as job insecurity leading staff to persevere at work for fear of losing employment; and because of their sense of duty, public service, and loyalty towards colleagues.

'…*they are coming in because of the fear factor that they may well lose their job as a result of them being off sick. But that could become a reality.'* (Union Rep, Org 3).

Nevertheless, informants believed this situation was not sustainable in the longer term as it engendered a sense of powerlessness, fear and resentment amongst staff.

Widespread organisational change was seen by managers as an opportunity because the consequent fluidity allowed them to challenge familiar customs and introduce new practices. There was evidence from line managers, occupational health clinicians and trade union representatives that the cultural resistance to facilitating temporary modified duties was eroding in an environment of reduced cover for staff on LTSA. Although this phenomenon is not commonly reported in the literature, we found that financial constraints compelled managers to think more creatively about offering temporary modified or alternative duties:

'…*maybe managers feel that they need to invest that time now in managing absence because they have so few resources… we need every pair of hands…'* (Assistant Director 2, Org 1).

Reduced resources were also having an impact on accountability for the management of SA. Although managerial accountability was identified as an important component of successful management of LTSA, performance management in relation to this responsibility had not been fully embedded, particularly at middle and line manager level. As a consequence many reported feeling overwhelmed and unsupported in making difficult absence management decisions. For example:

'*It's probably one of the hardest parts of being a manager, managing absenteeism*…' (Acute services manager 1, Org 2).

‘…*quite often managers they’re the meat in a sandwich and they’re getting squeezed from above and below*…’ (Union Rep, Org 2).

Contextual factors with more widespread effects: the inner context

In terms of the inner organisational context, we can draw some contrasts between the Trusts. Numerous participants within Org 1, including HR, OH, managers and union representatives, expressed a belief that a more stringent implementation of procedures had been responsible for a reduction in the levels of SA, particularly casual absence. For example:

‘I think our policy has been successful in that people see that absence is dealt with, that people do get terminated if they can’t provide consistent service at work’ (Senior HR Executive 2, Org 1).

In contrast, in both the interviews and the Process-Mapping workshops, numerous managers in Orgs 2 and 3 noted that, due to the risk-averse culture within their organisations, SA procedures rarely reached a definite outcome or end point such as termination of employment. This was thought to send an unhelpful message to employees:

‘…*but it’s sending out messages to those other colleagues who see this person malingering and nothing happens*…’ (OH Manager, Org 2).

This was related to an emphasis on the use of managers' discretion whether or not to implement SA procedures, particularly in Orgs 2 and 3, which resulted in widespread inconsistency and a lack of consequences for employees with persistent LTSA:

'…*some managers want to pick and choose when to apply the policy…some staff are managed to the letter of the policy, whereas other people aren't managed at all and I think that inequity makes us vulnerable*.' (OH Manager, Org 2).

The quality of communication was another important contextual factor. A variety of respondents reported that regular, two-way, respectful communication between managers and staff on LTSA led to the employee feeling supported and missed by colleagues, and provided an opportunity to discuss work and health issues. At the same time, the line manager could estimate the employee's time of return and forward-plan. This was less likely when the employee would not initiate contact; or the manager feared regular communication would be perceived as harassment or cause distress. Connected to this was the perception that when employees and managers show respect and good manners, both profit from mutual understanding. This extended to senior managers showing support for line managers and appreciation for staff providing cover for absent colleagues.

Another supporting practice was stakeholder collaboration, where all those involved worked together towards common goals, sometimes through formal

processes such as absence management forums. This was reported as leading to reduced duplication of effort and increased efficiency; whilst employees reported less isolation and greater empowerment. Conversely, when stakeholders misunderstood each other's roles, motives and objectives this led to an atmosphere of mutual suspicion and lack of cooperation.

Some respondents reported that accurate and detailed recording of SA was an important factor in enabling managers to target problem areas, thus improving their response to LTSA. However, respondents in all three organisations reported that the database software was not fit for purpose, and that compliance with systems for recording SA was poor, so this vital information was not available.

Impact of differing perceptions and beliefs

The results so far have shown the importance of the meanings attached to aspects of LTSA by various stakeholders. This was even more significant when people held conflicting perceptions and beliefs. These divergent views often produced a culture of mutual suspicion, with people placing negative interpretations on the actions of others. For example, there was a widespread perception amongst managers that some staff were malingerers, taking advantage of generous terms and conditions to avoid work whilst being paid:

'…*a significant enough number of staff can manipulate the system, are fabulous at manipulating the policy and it's very frustrating for managers*…' (Assistant Director 1, Org 1).

In this context of mutual suspicion, rehabilitative return to work is seen as the employee 'winning' against the organisation, making managers reluctant to offer this option:

'…*if you have a manager who feels that by letting that person back on a rehabilitative return is somehow giving in to that individual, you're in a no win situation, you really need to change that mindset.'* (Senior HR Executive 1, Org 1).

The other side to this coin is that some staff saw management procedures such as early referral to OH as '…*a form of institutionalised harassment…'* (Employee 1, Org 1); whilst others were working when sick for fear of a management process that would end in them unjustly losing their jobs:

'…from the staff point of view they see the policy as a big stick to beat them with basically... people are in fear of their jobs, there is no doubt about it.' (Union Rep 1, Org 1).

The concept of 'genuine illness' seemed to be deeply embedded throughout the three Trusts and numerous respondents highlighted the negative impact of making value judgements on this basis:

'…with the absence policy people bring on board their own personal beliefs and their value judgements and people make judgements about other

colleagues' conditions and whether or not that is a reasonable reason for being off… resulting in……overzealousness (towards) perceived malingerers and not implementing the policy with those who are perceived to be genuinely ill' (OH, Manager, Org 1*)*.

Evidence of misunderstanding extended beyond relationships between employees and their managers. Other stakeholders also experienced feelings of mistrust. For example line managers believed that they were being handed an unreasonable workload in managing SA, when this should be the responsibility of HR personnel: '*HR held our hands in many ways, now we have to do it ourselves*…' (Community Care Manager 2, Org 2). Similarly, GPs resented being made responsible for decisions about fitness for work when they saw their primary responsibility as diagnosis and treatment; whilst managers perceive GPs as too easily validating the sickness claims of employees [57]: '*The GP's medical certification pad is one of the most expensive pieces of equipment in the health service*…' (OHP 2, Org 2). Likewise, managers complained that OH physicians (OHP) recommended modified duties that managers saw as unreasonable, but they were reluctant to challenge the medical opinion.

'…the thing about long term sickness absence is that it is out of our control in many ways…I don't really have much control over what occupational health says…and I certainly have no input into the human resources part of it …' (Ward Manager, Org 1).

Meanwhile, the OHPs maintained that the decision lay with the managers and the medical opinion was not binding.

'*All I do is make recommendations, all HR do is make recommendations. It is up to the manager to decide how they implement those recommendations*…' (OHP 2, Org 3).

Impact of human relationships

'*...every policy needs to be humanised*…' (Senior Manager, Org 3).

This leads to the evidence from the case studies that the success of organisational procedures can depend on what are sometimes portrayed as the 'softer' factors of human relationships. Whilst there was good evidence that more easily defined approaches, such as early intervention, and rehabilitative return to work, sometimes had a positive impact on the management of LTSA; there was also evidence that they could become less effective or even counter-productive if human relationships were not taken into account. This is consistent with the realist approach underlying our research, which acknowledges the importance of the interpretations of the individuals involved and their consequent patterns of behaviour. For example, where line managers had clear accountability for managing LTSA, difficult decisions were not deferred and employees gained clarity on SA procedures and their consequences, so reducing uncertainty.

*'…I hold to account my heads of service…and then it's seeking assurances that the heads of service are holding their line managers to account.' (*Ass.Dir, Org 3).

'I think that it is a bit scary but I think when you are through the system, you realise that those people are only there to safeguard you.' (Employee 3, Org 1).

However, where accountability was imposed in a controlling way, without good access to senior managers, and without corresponding support and empowerment of line managers, it could engender suspicion and defensiveness.

Similarly, communication between managers and absent staff could have many positive effects but these were less likely to be evident when trust and mutual respect were absent; though more likely to be seen when the employee perceived a supportive, compassionate attitude in the manager:

'…*I had been saying look I hope that people wouldn't think they are carrying me…my line manager said sometimes people have to be carried, it's all part of a team working together.'* (Employee 1, Org 3).

Unintended consequences were also less likely to occur when relationships were taken into account. For example, early intervention was less likely to be

perceived as punitive when the experience was supportive and communication was face-to-face.

'*I think sometimes when you get people in and actually say how are you, they will divulge more than when they're on the phone.'* (Community Care Manager 1, Org 2).

Further, the success of interventions to manage LTSA and the avoidance of unintended negative consequences was often contingent on these relational factors. For example, communication between managers and absent staff was more likely to have a positive effect when the employee perceived a supportive, compassionate attitude in the manager but this could be undermined by a lack of trust and mutual respect.

In our study there was evidence that in some cases the quality of these human relationships mitigated the lack of focus and consistency in policy and procedure, allowing stakeholders to make the best of a relatively inefficient system. However, it is also important to stress the potential benefits of more proactive approaches. Participants reported that diligent application of policies, procedures and initiatives (such as early intervention and modified duties) could result in a general reduction in uncertainty and an increase in equity; in managers feeling empowered and employees valued and supported.

The vital role of line managers

The key part played by line managers emerges strongly from our research; for example in their frequent and sustained appearances in the Process Maps for all three organisations. They have a dual responsibility to support the sick employee and to represent the interests of the organisation, which is a challenging task:

'The line manager has to be able to get the balance right between supporting the member of staff and helping the member of staff to understand that it is appropriate for an organisation to manage and control attendance.' (Senior HR Executive 2, Org 1).

Senior managers believed they could make it is easier for line managers to strike this balance by calling them to account for LTSA and also supporting them in their decisions:

'…nothing is black and white and there are very much grey areas so what helps is that yes there is accountability down through the system but there is also a method to feed back up through the system…to a more senior level…' (Ass.Dir 2, Org 1).

'…*managers are not afraid to address issues with employees because they are supported to do this at senior management level' (*Senior Manager, Org 3)

However, line managers did not always feel supported; nor that accountability worked its way through to the employee:

'*In times gone by you would have had the support of the senior manager…now the senior manager wouldn't know the staff in the department*.' (Ward Manager 1, Org 3).

'…*in 18 years involved in line management...we have never brought anybody to discipline for sick leave…there tended to be a fear of somebody, somewhere making a decision*…' (Community Care Manager 2, Org 2).

Line managers believed that the organisational failure to properly hold employees to account showed a lack of respect for staff who had to pick up the extra load:

'…*it's difficult to show hard-working staff that they are valued when the Trust tends not to punish bad absence behaviour…saying thank you wears thin after a while*…' (Acute Care Manager 3, Org 3).

From the employees' point of view, whilst over-zealous adherence to procedures could be experienced as uncaring harassment, lack of contact with their line manager could be perceived as neglect:

'…*I was a wee bit miffed to be honest, after this length of time no contact from any management…it does sort of leave you a bit more frightened about going back to work*…' (Employee 1, Org 2).

To summarise, it appears that line managers occupy a unique position in relation to LTSA, representing both support and accountability to the sick employee. However, if they are to fill this role effectively, they in turn need to experience support from and be held accountable to their senior managers; who themselves must ensure that the organisation follows through on disciplinary aspects of SA management.

Analysis and discussion

Having formulated our initial DPTs and tested them at stage two, we were able to assess how far the DPTs had been supported or modified by our findings.

DPT One - Early intervention in the form of regular contact with absent staff initiated by employers

This programme theory was broadly supported in our study (Figure 1). However, further contextual factors were also reported: that managers sometimes delayed intervention either because they simply did not believe early intervention worked, or where absence related to culturally sensitive areas such as miscarriage or mental illness; and that early intervention was less likely to be well received when the employee saw it as punitive.

Figure 1: DPT One - Early Intervention in the form of regular contact with absent staff initiated by employers

DPT Two - robust sickness absence policies with clear trigger points for management action

This programme theory was supported in that clear policies served to reduce uncertainty for managers, employees and other stakeholders (Figure 2). There was also support for the effectiveness of sanctions, both positively and negatively, in that participants reported that policies were ineffective when sanctions were not implemented, and that this failure to follow through discouraged line managers and staff who continued to work. Some of the contextual factors were also supported, especially the importance of senior manager support and training for line managers. We had no single level, small organisations, so could not comment on this aspect of organisational size. However, both the Process Maps and interviews with managers and other stakeholders pointed to the difficulties implementing policy in a large, geographically spread organisation with strong professional boundaries.

Figure 2: DPT Two - robust sickness absence policies with clear trigger points for management action

DPT Three – Workplace-based multidisciplinary occupational rehabilitation and provision of modified duties

This programme theory was broadly supported by our research (Figure 3), with participants reporting agential motivations such as increased confidence to return to work and work relationships. An additional contextual factor was identified: greatly reduced availability of replacement staff for those on LTSA

had motivated senior and line managers to use modified duties more extensively.

Figure 3: DPT Three – Workplace-based multidisciplinary occupational rehabilitation and provision of modified duties

DPT Four – Personal involvement of senior managers or specialist case managers

Personal involvement of senior managers did appear to assist line managers to engage in effective management of LTSA (Figure 4). Both the mechanisms and contextual factors identified at stage one were broadly supported. An additional contextual factor was identified: senior managers were less likely to engage when they feared the employee would resort to an employment tribunal or to litigation. In terms of agency (A), we were able to discern two sets of cognitive and affective beliefs amongst line managers. The first was with reference to their relationships to senior managers. Personal involvement of a senior manager who encourages the line manager to take responsibility for LTSA engenders a greater sense of accountability in the line manager, together with increased confidence that their senior manager will support them in the (sometimes difficult) processes involved in managing LTSA. The second relates to engaging with the necessary procedures. Where line managers feel a sense of ownership and personal confidence in their right and ability to manage LTSA, they are more likely to proactively implement procedures (such as early intervention and workplace based rehabilitation), and take local decisions promptly (O). Line managers are less likely to engage in this way when they have difficulty balancing their supportive and procedural

roles, and when they lack confidence in their own judgement (for example in their ability to challenge the opinions of OH physicians) (C).

Figure 4: DPT Four – Personal involvement of senior managers or specialist case managers

DPT Five - Line managers initiate regular communication with the absent employee

In addition to the four DPTs identified by realist review, a further programme theory emerged from analysis of the empirical data. When a line manager engages in regular communication with an absent employee (M), the employee feels that they can trust the manager, and that the manager (and other colleagues) supports and understands them (A). This allows discussion of issues that may be a barrier to the employee's return and an estimate of time to return to work, which facilitates forward planning (O). Communication is more likely to succeed when it is respectful, two-way, and where the manager conveys a desire for the employee to return to work; it is less likely to happen when the manager fears regular communication will be perceived as harassment or cause distress, or where the employee refuses to respond (C). DPT Five is an intervention in that regular communication can be planned and implemented but it obviously pervades all interventions that require the line manager to communicate with the absent employee (Figure 5).

Figure 5: DPT Five - Line managers initiate communication with the absent employee

Synthesis of the dominant programme theories

Drawing the DPTs together it is possible to discern a number of interrelationships and produce a model for the management of LTSA in large public sector healthcare organisations (Figure 6). It appears that where a senior manager engages in personal facilitation of the line manager in relation to their management of LTSA, and provides clear guidance on how this is to be done, the line manager can develop a sense of ownership, with increased confidence in their own ability and right to manage LTSA, and also in organisational and senior manager support should difficulties arise. This in turn encourages line managers to proactively implement processes to address LTSA, such as early intervention and workplace-based rehabilitation, to take decisions in a timely way, and to engage in regular communication with the absent employee. The interaction of line manager and absent employee can engender in the employee a sense that the line manager and other colleagues understand and support them, and that the line manager can be trusted. This potentially leads to the employee developing the confidence to return to work.

This interaction of interventions, mechanisms, and outcomes is more likely to be seen in the context of larger, unionised organisations, with well-defined structures; where the senior manager has good relationships with the line manager and with trades unions, and encourages the line manager to take responsibility for LTSA; where the line manager is adequately trained and resourced; where financial pressures and lack of replacement staff encourage

the line manager to consider more flexible return to work practices; and where the line manager's communication with the absent employee is respectful and reciprocal, and conveys a desire for the employee to return to work. The interaction is less likely to occur in the context of an organisation which is geographically and professionally fragmented; where senior managers, line managers and other departments have conflicting perspectives, priorities and agendas; where line managers have difficulty combining supportive and procedural roles in relation to employees; where co-workers resent or resist modified duties for returning staff, or the line manager believes absent employees must be completely fit before returning to work; and where the line manager fears contact with the absent employee will be seen as harassment, or the employee sees contact as punitive and refuses to respond.

Contextual factors with more widespread effects

In addition to the contextual factors examined in relation to the programme theories, we found several important aspects of the context that had a pervasive effect on the identified mechanisms. These were not absent from the literature but they came through with unexpected power in our data. First amongst these was the vital role of line managers [47, 48]. These are the managers who are most closely involved in dealing with LTSA, as was demonstrated in the Process Maps. They are central to managing LTSA: supporting the absent employee and also representing the interests of the organisation. It was evident that they needed practical and personal support from their seniors to effectively discharge this challenging responsibility [12, 53]. Two closely related aspects of the context were the impact of differing

perceptions and beliefs and of the quality of human relationships amongst stakeholders. We found that divergent views and perceptions about the roles and motives of the various parties involved often led to misunderstanding and mutual suspicion, which hindered collaboration. Similarly, the effectiveness of programmes to manage LTSA and the avoidance of unintended consequences was influenced by the quality of relationships between the parties. These observations were consistent with literature showing that many managers were suspicious of employees' motives; whereas the employees' view of absence management procedures often depended on the level of communication and personal relationship they had with their manager [15, 58, 59]. We should make clear that by good relationships we do not mean that everyone must like their colleagues, or make them personal friends. Rather we mean relationships characterised by integrity, mutual respect and understanding, so that colleagues build trust, which in turn engenders cooperation [43, 48, 60]. Our observations are also consistent with the wider literature on human relationships in the NHS, which emphasises the importance to health care organisations of collaborative relationships and leaders who, through personal integrity, and their supportive and inclusive approach, gain the trust and cooperation of colleagues [61, 62]. It is easy to relegate the quality of relationships between colleagues to the purely personal sphere but this is to ignore the impact that these can have, for good or ill, on the functioning of the organisation. As Meads and Ashcroft argue, 'If effective delivery requires collaboration between individuals, professions and organisations, then the obstacles to such collaboration must be overcome.' [61]. Leaders can build trust by showing respect, fairness and openness; they

can lose it through hidden agendas, inconsistency, and tolerating poor behaviour [2, 15, 16, 60]. In the field of LTSA management two recent reviews of the qualitative literature on return to work following injury reported similar findings. Successful return to work was based not only on improvements in physical functioning but was influenced by the beliefs and perceptions of the various stakeholders, and the level of goodwill between them. Positive outcomes often depended on the degree of trust between employers and absent staff [43, 56].

Turning to the outer context, we found that the radical structural changes and reduction in resources experienced by the trusts had mixed effects on LTSA. On one hand, perceived job insecurity was thought to have reduced casual sickness absence, whilst the relative fluidity of the change period and the squeeze on resources for replacement staff had encouraged and enabled managers introducing new practices such as workplace rehabilitation. On the other hand, the lack of cover for absent staff was placing a strain on those at work, exhausting their goodwill and possibly increasing their risk of sickness. There were also some reports of an increase in ‘presenteeism,’ where staff come to work despite health problems and may perform suboptimally, or become more sick [1].

Limitations of the research

Some limitations of the research were caused by situational factors. For example, we were unable to gain numerical data on the nature and extent of LTSA, largely because the Trusts themselves had access only to aggregate

SA data, which limited our ability to quantify outcomes. This is a perennial problem in researching SA and would appear to be an obvious first step in managing a challenging issue for the health and social care sector, as well as other organisations.

Another situational factor was that the research coincided with a period of major structural change within the HSC Trusts. Whilst this provided a rich environment for information on contextual factors, it could not reflect a stable picture of routine organisational activities in absence management over the duration of the data collection. However, realist evaluation recognises that systems are active and constantly evolving and therefore the study design was able to incorporate the changing inner and outer context as part of the research findings [22, 25].

In terms of methodological limitations, we are concerned that the adoption of realist evaluation resulted in a lack of criticality. Realist evaluation attempts to eschew any social values smacking of utopianism and to stick to piecemeal social engineering [63]which involves explaining the decisions of policy makers, rather than condemning them [28]. The problem with this piecemeal pragmatism is that it can lead to an implicit social conservatism that neglects the issues of power and inequality [64]. In this case, our almost exclusive concentration on mechanisms purported to deal with the ‘problem’ of LTSA meant that little attention was paid to the highly contested area of social rights during sickness [65]. Instead, our discussion was positioned on the terrain carved out by Talcott Parsons and his view that ‘the problem of health is

intimately involved in the functional prerequisites of the social system ... so that ... too low a general level of health, too high an incidence of illness is dysfunctional' [66]. This perception concentrates on the negative consequences of absenteeism while neglecting the benefits of social security, and fails to interrogate this analytic imbalance. We suggest that the incorporation of critical realist strategies [67] into our research design would have enabled a more robust analysis of the consequences of these policies and procedures for employees in terms of power, equality and autonomy [64].

Conclusions and recommendations

The dominant programme theories derived from our realist review of the literature were for the most part supported by our data; and none of them were undermined by our research. A number of additional contextual factors were also identified. These related especially to the differing perceptions of stakeholders in relation to LTSA and the degree of trust and mutual understanding between them. These factors are not absent from the literature, but came through with unexpected strength in our research.

With reference to our aims and objectives, we conclude the following. The core activities influencing effective management of LTSA included early intervention by managers and OH departments; the provision of policies on the management of LTSA which clearly state the actions required of both managers and employees; workplace-based occupational rehabilitation with

provision of modified duties; and the personal involvement of senior managers to provide both support and accountability to line managers, and to ensure they are trained to use organisational procedures with diligence and diplomacy. However, it is not sufficient for organisations merely to arrange for these activities to be carried out. If the chances of success are to be optimized, it is important to recognise *how* they work and in what circumstances.

It is evident from our final DPTs that different mechanisms have the potential to foster common agential motivations. In relation to employees suffering LTSA, being motivated to return to work and having the confidence to do so is at the heart of DPTs One, Three and Five. It is also evident that motivation is a crucial link in the causal chain. Thus, DPTs Two and Four show that the authority and confidence of the line manager are key factors leading to more effective management. Consequently, when addressing LTSA, it is important for both senior and line managers to consider how they can intervene to increase the likelihood that these motivations will be fostered. Rather than a mechanical prescriptive approach, this calls for a thoughtful, diagnostic process, taking into account the contextual factors (and whether they can be modified) and considering how any intervention can be used to encourage the appropriate motivations. With this context-dependent diagnostic approach in mind, we are able to make some broad recommendations.

Drawing on DPT One in relation to early intervention, when initiating early contact with an absent employee it is important for line managers to use this

contact to identify any barriers to return to work, and to seek to assure the employee of their interest and support, with a view to increasing the employee's desire and confidence to return. In the light of the contextual factors identified in the DPT, the line manager may also seek to allay any fear the employee has that early contact is a form of harassment or punishment. Meanwhile, senior managers will want to make sure line managers are well trained in carrying out SA policy, including where the illness is culturally sensitive, and that the key departments communicate well.

With regard to our DPT on sickness absence policies; senior managers should make sure that staff are provided with policies and procedures on LTSA that clearly state the actions required, that line managers recognise their authority to follow these through, and that there are rewards and sanctions for employees depending on their compliance with procedures, with a view to motivating return to work. With reference to the contextual factors, senior managers should take into account the size and complexity of their organisation when planning policies and providing resources to manage SA, and make sure that managers are appropriately trained and resourced to meet the expected challenges.

Turning to our DPT in relation to workplace-based rehabilitation and provision of modified duties, senior and line managers should support this by providing suitable opportunities - if possible in the employee's usual workplace - so that the employee can re-establish working relationships and gain confidence to return to work. In the light of the contextual factors, senior managers should

take advantage of reduced resources and organisational change to look for opportunities to introduce these practices if they are not in place. Training of line managers should include a focus on helping them to think creatively about modified duties, about overcoming resistance amongst staff, and to recognise that the employee need not be completely fit to return to work.

When senior managers consider our DPT in relation to their personal involvement in ensuring good communication between themselves, line managers and other relevant departments, and supporting their line managers in the development and implementation of a plan for return to work they should seek to foster an increase in accountability, ownership, and confidence amongst line managers, whilst assuring them of organisational support should challenging circumstances arise. Considering the contextual factors, managers will want to work on securing good relationships with each other and with trade union representatives, and will actively seek to reconcile different perspectives and priorities amongst stakeholders.

Coming to our new DPT Five, line managers should ensure that their communication with absent employees is regular, respectful and two-way; that it includes discussion of issues that may be a barrier to the employee's return, and conveys their desire for the employee to rejoin the team. Employees can contribute to the process by responding positively to such communication.

Finally, considering our synthesis of the dominant programme theories, what is striking is the interaction of organizational structure and resources,

interventions to address LTSA, and the human relationships of stakeholders. This is especially evident in relation to the performance of line managers in relation to LTSA. They must support the sick employee but also call them to account, which is a challenging combination of responsibilities, all the while negotiating a long and complicated set of processes. Their effectiveness in this partly depends on the quality of the training they receive and also on the support and accountability they experience from their senior managers, who themselves must ensure that the organisation follows through on disciplinary aspects of SA management. All of this vitally influenced by the impact of differing perceptions and beliefs - which could lead to misunderstanding, mutual suspicion, and poor cooperation - and the quality of relationships between the parties. It seems that the success of interventions to manage LTSA and the avoidance of unintended negative consequences are often contingent on both organisational resources and the ability of stakeholders to operate with openness and mutual respect.

List of abbreviations

Ass. Dir: Assistant Director

DHSSPS: Department of Health, Social Services and Public Safety

Employee: Employees experiencing LTSA i.e. returning to work following a period of long-term sickness absence in the previous three months

Dir: Director

DPT: Dominant programme theory

GP: General Practitioner (community physician)

HR: Human Resources

HSC Trust: Health and Social Care Trust

LTSA: Long-term sickness absence

MSD: Musculo-skeletal disease

NHS: National Health Service

OH: Occupational Health

OHP: Occupational Health Physician

SA: Sickness absence

UK: United Kingdom

Union rep: Trade Union representative

Competing interests

None declared.

Authors' contributions

AH, PO and SP planned the study, participated in data analysis, and drafted the manuscript. AH carried out the data collection with assistance from PO for the Process Mapping. All authors read and approved the final manuscript.

Acknowledgements

This article presents research that was funded by the Health and Social Care Research and Development Office in Northern Ireland. The authors would also like to thank all the participants who contributed to the research.

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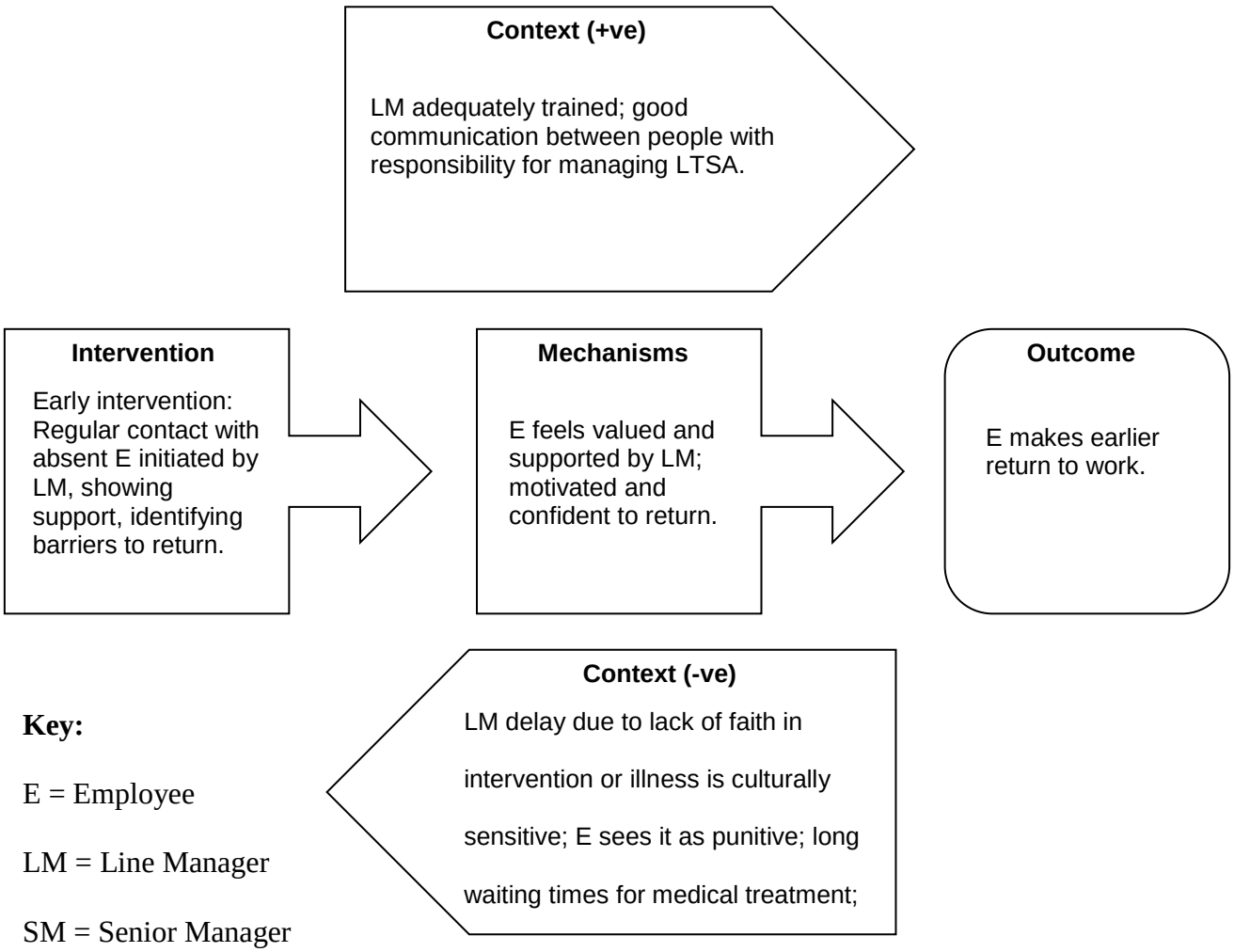
Table 1. Data collection

	STAGE 1 (Jun 09 – April 2010)			STAGE 2 (May 2010-Apr 2011)	
	Method/No.	**Participants**		**Method/No.**	**Participants**
DHS SPS	Interviews/2	Senior policy-makers		Interviews/1	Senior policy-maker
GPs	Interviews/3	One GP serving each Trust area			
Org 1	Interviews/11	HR executives, senior, middle, and OH managers, Union reps		Repeat interviews/5	Selection from stage 1
	Process-Mapping/15	HR and middle, managers, OH staff, Union reps		Interviews/5	Employees experiencing LTSA
	Observation of training/18	Middle and line managers		Feedback meeting/10	Lead researcher and HR executives, senior and OH managers
Org 2	Interviews/9	HR executives, senior, middle, and OH managers, Union reps		Repeat interviews/5	Selection from stage 1
	Process-Mapping/6	HR and middle, managers, OH staff, Union reps		Interviews/4	Employees experiencing LTSA
	Observation of training/40	Middle and line managers		Feedback meeting/8	Lead researcher and HR executives, senior and OH managers
Org 3				Interviews/16	HR executives, senior, middle, OH managers, Union reps and employees
				Process-Mapping/11	HR and middle, managers, OH staff, Union reps
				Observation of training/35	Middle and line managers
				Feedback meeting/9	Lead researcher and HR executives, senior and OH managers
Key	DHSSPS: Department of Health, Social Services and Public Safety; GP: General Practitioner (community physician); HR: Human Resources; OH: Occupational Health; Union rep: Trade Union representative; Employees experiencing LTSA: Returning to work following a period of long-term sickness absence in the previous three months				

Figure 1: DPT One - Early Intervention in the form of regular contact with absent staff initiated by employers



Key:

E = Employee

LM = Line Manager

SM = Senior Manager

Figure 2: DPT Two - robust sickness absence policies with clear trigger points for management action

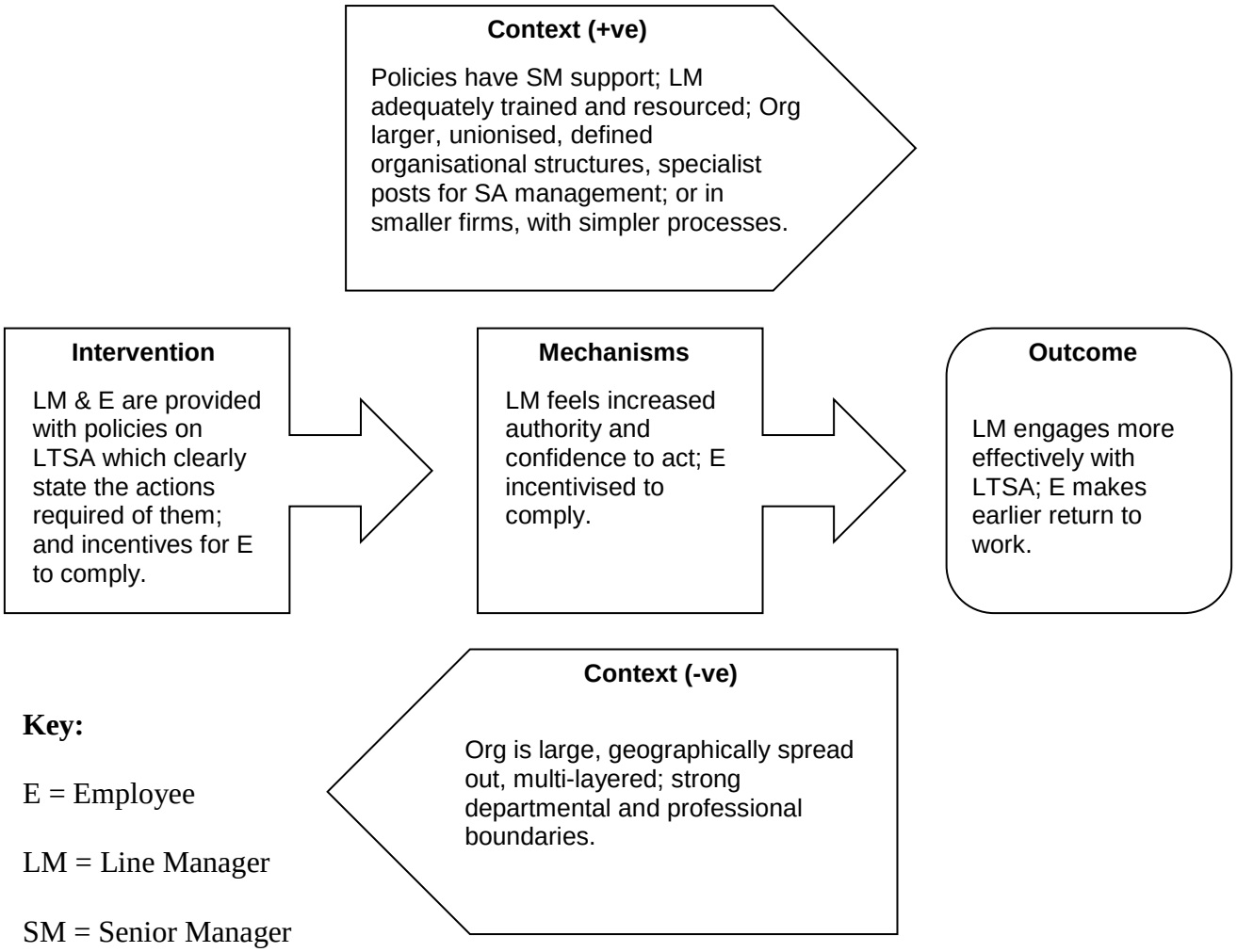


Figure 3: DPT Three – Workplace-based multidisciplinary occupational rehabilitation and provision of modified duties

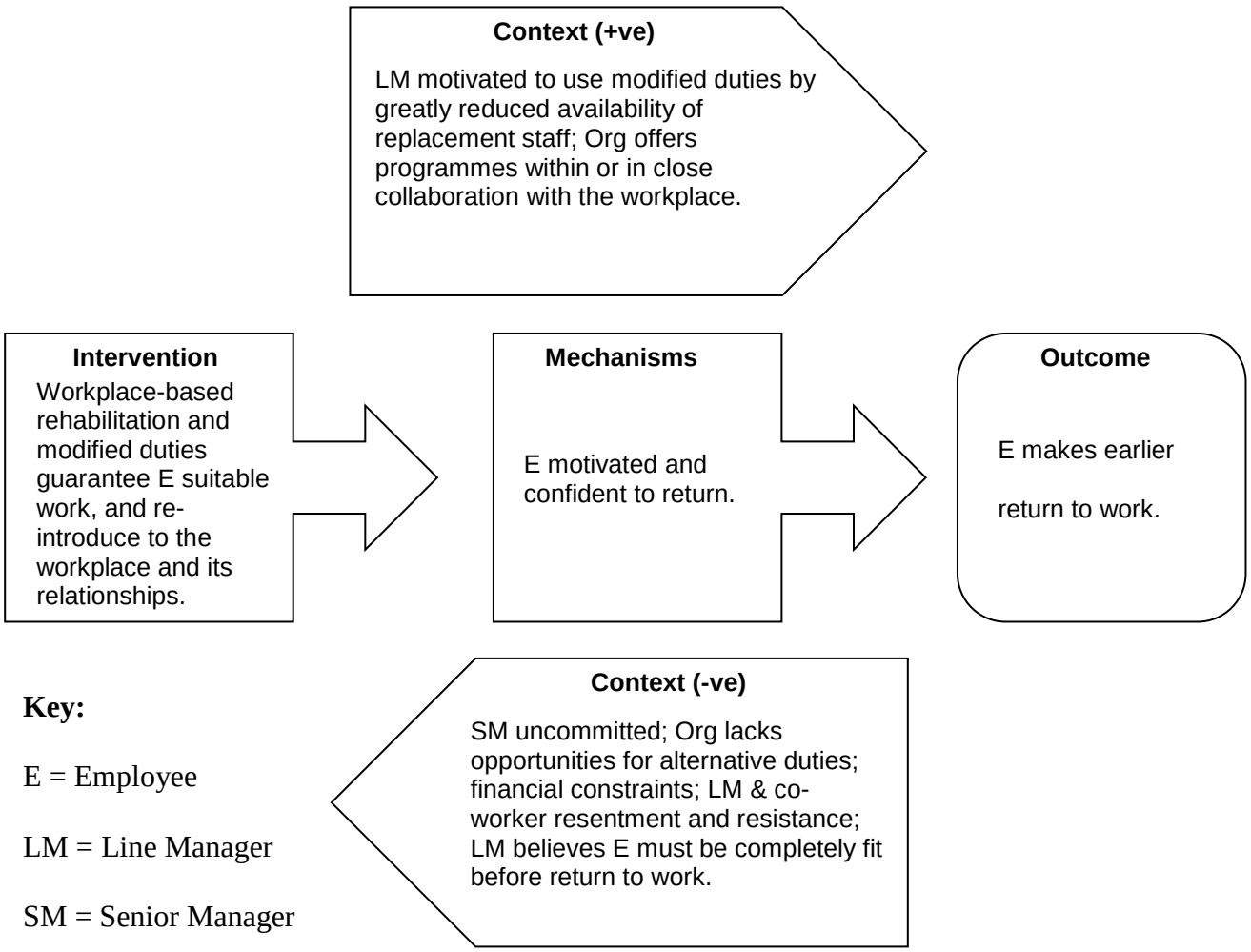


Figure 4: DPT Four – Personal involvement of senior managers or specialist case managers

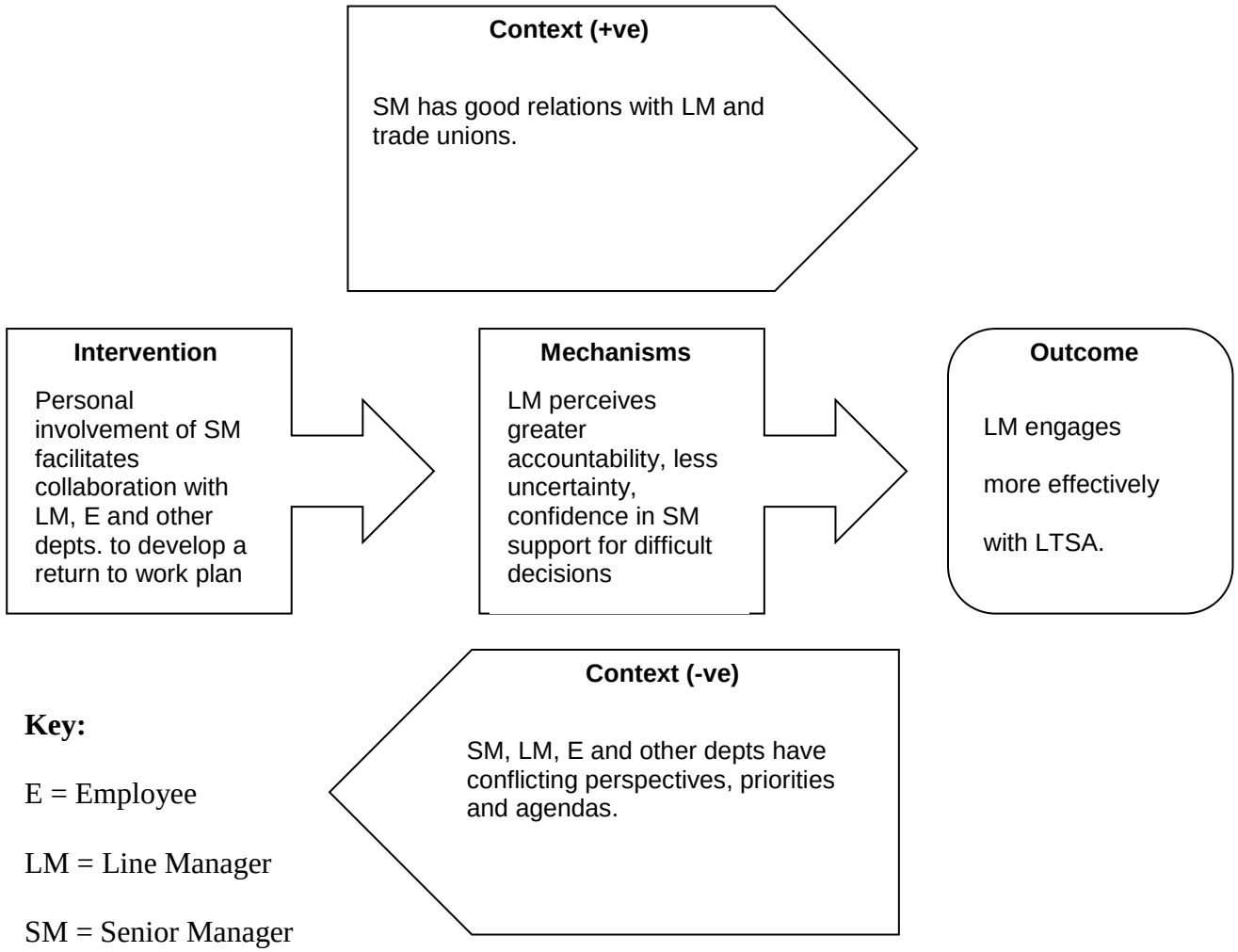
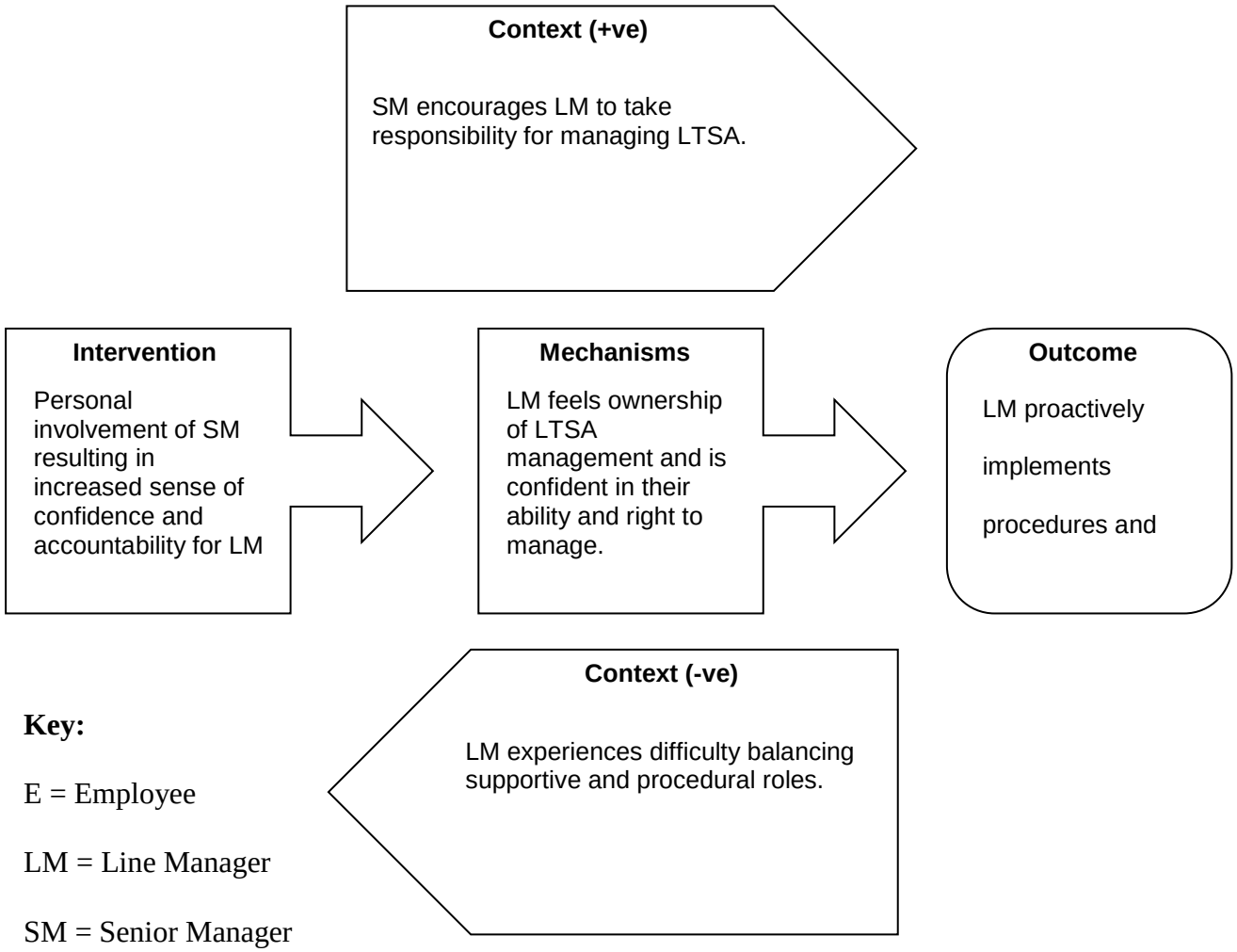
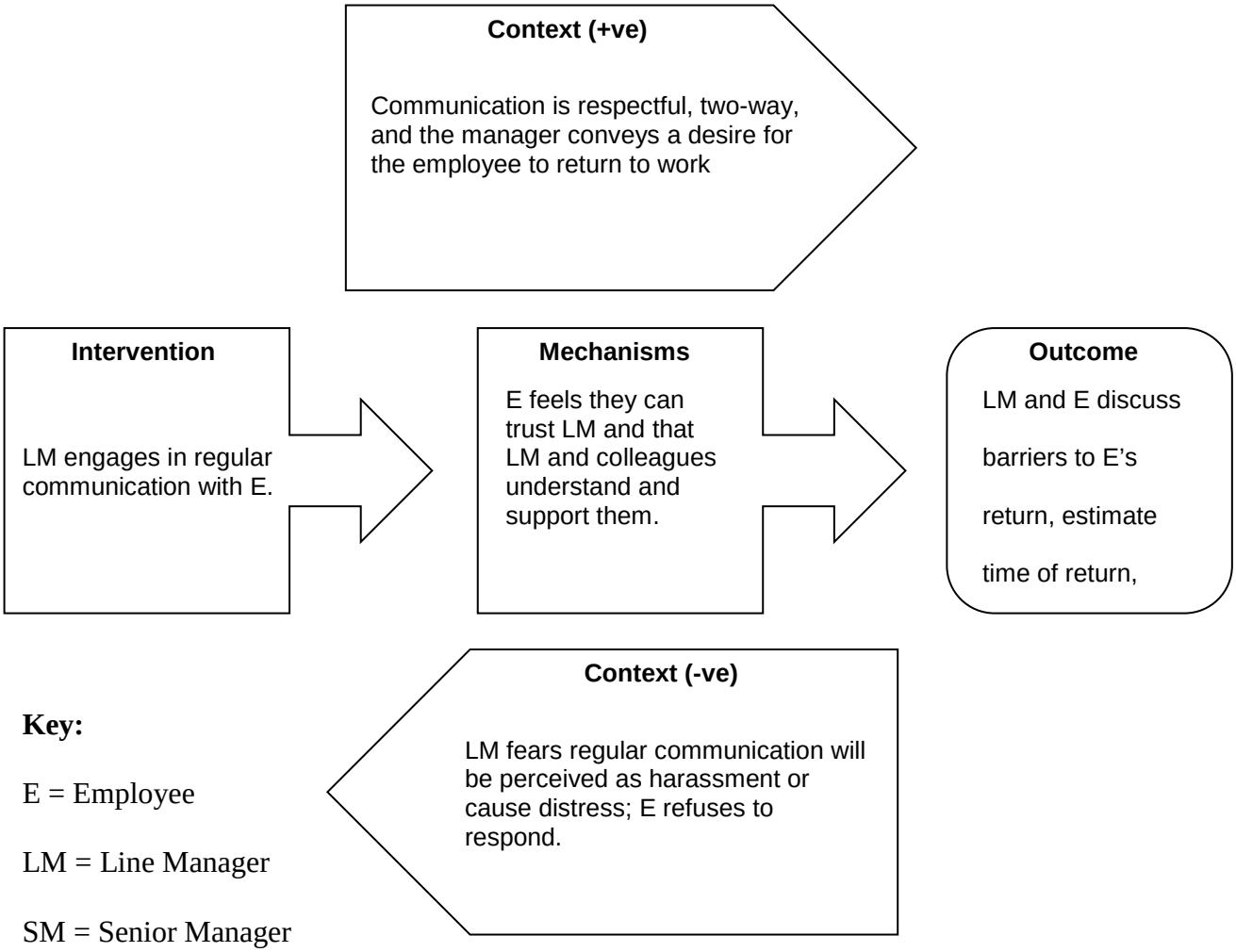


Figure 5: DPT Five – Line managers take ownership of LTSA management

Note: This DPT focuses on the outcome of DPT Four, 'LM engages more effectively with LTSA' and describes *how* the LM becomes more effective. Thus the intervention in DPT Five is the intervention in DPT Four ('Personal involvement of SM') together with the mechanisms triggered by that intervention, and the contextual factors for DPT Four will also affect the outcomes of DPT Five.



DPT Six - Line managers initiate communication with the absent employee



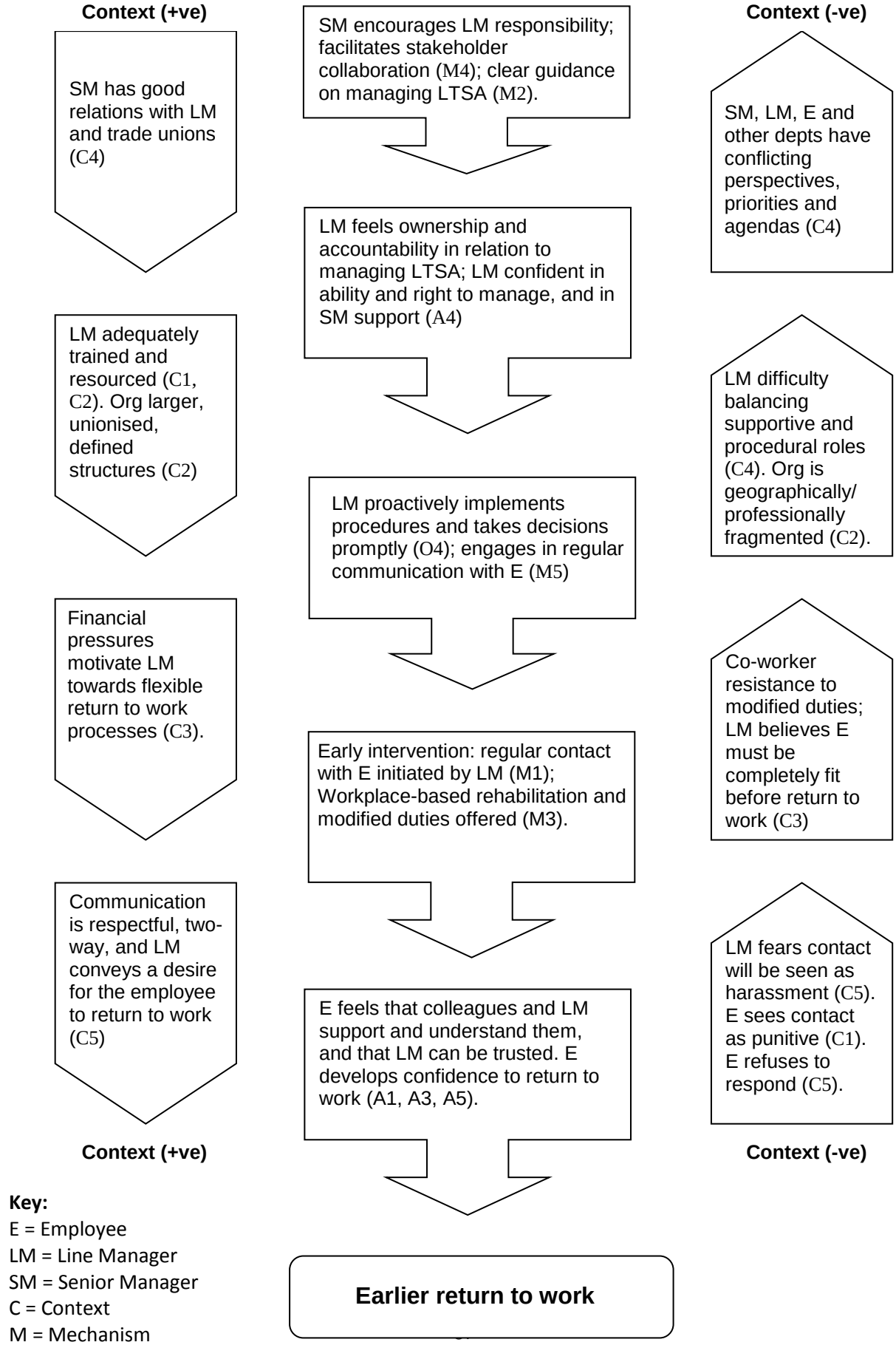
Key:

E = Employee

LM = Line Manager

SM = Senior Manager

Figure 6: Management of long-term sickness-absence in large public sector healthcare organizations: an integrated model



Key:
E = Employee
LM = Line Manager
SM = Senior Manager
C = Context
M = Mechanism
A = Agency
O = Outcome
(Numbers link CMAO to DPTs)